Submission No 66

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Australasian College for Emergency Medicine

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Inquiry into Equity, Accessibility and Appropriate Delivery of Outpatient and Community Mental Health Care in New South Wales

1. Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to make a submission on the Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales (the Inquiry). Our submission highlights the concerns, experiences, and insights from emergency physicians in New South Wales (NSW) regarding the high-volume of acute mental health presentations and persistent systemic issues regarding access block and inadequate access and availability of community based mental health support.

2. About ACEM

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for ensuring the advancement of emergency medicine in emergency departments (EDs) across Australia and Aotearoa New Zealand, training emergency physicians in these regions, and accreditation of EDs for emergency medicine training.

3. Overview

ACEM acknowledges that the Inquiry's focus is on community-based services, however, depending on the acuity of a person's mental health condition they may require care from, emergency departments, inpatient units, or community-based services. There is a connection between these three types of services at various points of the mental health and recovery journey.

As found in ACEM's The Long Wait (2018) and Nowhere Else to Go (2020) report the mental health system is highly fragmented, and this is consistent across all jurisdictions. Therefore, ACEM's submission will demonstrate how inadequacies, lack of access, and fragmentation in community-based mental health services contributes to pressures in EDs, access-block for mental health patients, which can contribute negative patient outcomes.

ACEM recognises the importance of accessible community-based services tailored to different needs. Initiatives like the Police and Clinician Emergency Response (PACER) and Safe Space models are valuable system enhancements that have provided a step between ED and community, and access to crisis support. This is particularly important in terms of entry point, as currently many people have no where else to go, so attend the ED, even though EDs are not designed or resourced for mental health support, other than acute crisis. There is not a one size fits all approach to managing and treating the numerous mental health conditions; EDs are not suitable for the spectrum of mental health needs, likewise, community-based services often are unable to meet people where they are on their journey.

4. Mental health care in the emergency department

Many people present to EDs for mental health care because they cannot find or afford care in the community. Regardless of whether people are experiencing mental illness for the first time, a crisis outside of business hours or have a long-standing condition, the ED is a far from ideal environment to provide ongoing, or situational crisis care. There should be alternative after-hours community-based services available that can be accessed by people when they need it, particularly in areas where mental health presentations to EDs are high.

Emergency departments are busy high stimulus environments that can contribute to escalation of behaviours and symptoms and are exacerbated by extended lengths of stay. This scenario can have a negative impact on patient outcomes. Therefore, reducing the risk of escalation and deterioration to the mental health whilst people are in the community is a priority[1].

The level of mental health care that can be provided from the ED is influenced by access to mental health teams, clinicians, availability of in-patient beds and discharge options in the community. Typically access to psychiatry is only available during business hours, whereas the ED is a 24-hour service.

EDs can assess and triage patients, and make a determination for further psychiatric assessment, support de-escalation and stabilisation, and transfer or discharge. EDs are not places for ongoing psychiatric care, yet there is an apparent disconnect between community and the ED on what level of care can be provided. ACEM acknowledges that primary presentations for mental health to the ED, that are not acute enough to warrant admission yet do not receive a clear picture of longer-term support can be distressing for patients and their families and carers.

1) Recommendation: ACEM recommends the New South Wales Government commits to boosting the entire mental health system, to provide supports that meet peoples needs across the spectrum of care.

2) Recommendation: Extend operational hours of psychiatry and mental health specialists to the ED, to mitigate long-wait times for assessment, ward transfer or discharge.

3) Recommendation: The New South Wales Government develop improved modes-of-care that can link lower-acuity mental health patients presenting to EDs with community-based services post-discharge.

5. Demand for mental health care from emergency departments

People presenting to EDs in mental health crisis often have other complex needs including physical health comorbidities, drug and alcohol abuse problems, or require support to address broader social circumstances, including homelessness.

ACEM's analysis of presentation data shows NSW EDs are being called on to provide a volume, range and complexity of mental health services without the resources, infrastructure or whole of hospital systems necessary to keep up with demand and provide timely and appropriate care.

Over the 2021-22 period there were 85,281 mental health presentations to NSW EDs, equating to 3% of all presentations. 28% of mental health related presentations were admitted to the presenting hospital. Of the total number of presentations, 22% were defined as mental health due to psychoactive substance use, 26% as were neurotic stress relation and somatoform related disorders and 20% was for mental disorder, otherwise undefined. 49% of mental health presentations arrived by ambulance, and 6% by police, compared with total ED presentations of 22% and 0.5%

[1] Pascoe, S.E., Aggar, A. & Penman, O. 2022. Wait times in an Australian emergency department: A comparison of mental health and non-mental health patients in a regional emergency department. *International Journal of Mental Health Nursing.* Vol.31.

respectively.[2] This demonstrates that the acuity of presentations for mental health upon arrival is high, management of drug effected presentations can take longer and is highly complex, and presentations arriving by police require additional considerations to appropriately manage.

4) **Recommendation:** Increase access to community-based services that can support mental health and drug and alcohol comorbidities.

5.1 Access Block

Australian data confirms that patients presenting to emergency departments (ED) for mental health care routinely experience excessive and unreasonably long waits for both assessment and ongoing mental health care, often in inappropriate and, at times, unsafe environments. It is a constant challenge for ED staff to find a timely and safe path for patients, such as admission to an inpatient bed or home with appropriate community support in place.

Unfortunately, many patients awaiting admission to a mental health inpatient unit experience significant delays in emergency department patient flow (due to lack of available hospital beds). This leads to delays in the treatment of new patients (as emergency department staff are managing access-blocked patients).

In NSW, 90% of patients in NSW EDs were seen and admitted within 22 hours and 33 minutes and waited a median of 7 hours and 14 minutes. 90% of non-admitted patients were discharged within 11 hours and 31 minutes, and the median wait time was 3 hours and 27 minutes. AIHW data also shows that whilst mental health presentations and admissions over the past six reporting periods has slightly decreased, median length of stay time has increased by approximately 1.5 hours since 2017-18.

Further, ACEM's 'Hospital Access Targets' (HATs), is an access measure that describes three patient streams and sets distinct time-based targets for those streams. The maximum length of emergency department stay recommended by HATs for any one stream is 12 hours. For this stream, the target should be 100%, but in 2018-19 77.8% of patients, and in 2020-21 75.2% of admitted or transferred patents met this target. Over the past three years NSW EDs performance based on HATs has continually decreased across all measures. For example, HATs recommend 80% of patients are discharged under four hours; in 2018-19, NSW met 71.1%; 2019-20 was 68.7% and in 2020-2021 62.9% were discharged within the recommended length of stay.[3]

There are numerous factors contributing to increased wait times in ED. This performance data has been provided to demonstrate wider systemic concerns related to access to mental health treatment and care in the hospital and also suggests there is a lack of access to community-based supports, so patients and their carers are dependent on the ED for immediate mental health support. Spending prolonged periods of time waiting to be moved to a mental health bed may exacerbate the problem that the patient presented with, adversely impacting on their care and outcomes.

To reduce reliance on EDs, communities across NSW need access to mental health care outside of business hours, and ED staff need pathways for referrals into community-based service, including for housing and drug and alcohol services. An integrated model of care is needed that can provide enhanced, trauma-informed services and support, tailored to respond to the needs of the most vulnerable groups of people with mental illness.

5) **Recommendation:** Increase access to after-hours mental health services for lower-acuity patients, and as an alternative to the ED environment.

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[2] Australian Institute of Health and Welfare, 2022. Mental health services in Australia. Canberra: Australian Institute of Health and Welfare. *Available from:* https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments#data-source

[3] National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD).

6. Unacceptable standards of care

Emergency departments provide a compelling window into the strengths and weaknesses of NSW mental health system. It is ACEM's position that mental health care and treatment outside of the tertiary care system is preferred where possible and has positive patient and recovery outcomes. However, ACEM is concerned that across jurisdictions, governments are prioritising community-based bed capacity, whereby inpatient bed capacity is increasingly in demand, resulting in unsafe wait times in ED for admission.[4]

Community-based higher acuity services, like step-up step-downs are a favourable option and alternative to clinical in-patient units, providing an appropriate level of care to patients who might not be well enough to be in the community. However, the system must be equipped with an appropriate stepped approach so those in crisis, do have access to a hospital bed, without prolonged wait times, can stabilise then transition to lower-acuity community-based supports.

The OECD has emphasised that an effective mental health system requires a balance between adequately funded community-based services and in-patient services.[5] There is emerging evidence that the national policy emphasis on the reduction of psychiatric bed numbers in favour of community services has had several adverse consequences including on rising rates of psychiatric boarding in emergency departments.[6]

There will always be some people that experience undulating levels of deterioration dependent on the mental health condition and acute services must adequately meet demand. This is particularly relevant in the context of comorbidities, related to drug-use considering the upwards trend of people presenting in drug-induced psychosis. Ideally, initial assessment and management should occur in a calm quiet environment that is dramatically opposed to the typical setting of an ED. [7]

A chronically under-resourced mental health system means too many people cannot find or afford an appointment in the community, while stigma and a lack of confidence in the system means many people delay presenting until they are in crisis. In this chronically under-staffed and under resourced service system, the regular state of access block in inpatient mental health units and the shortage of after hour's care in the community contribute to dangerous levels of access block and overcrowding in the ED. People who are often in extreme distress or behaviourally disturbed regularly wait for hours and often days in EDs, with breaches of admission targets being routinely tolerated by hospital administrators and governments. Emergency physicians are profoundly frustrated and demoralised by trying to provide safe, quality care for people in this environment. Not to mention the vicarious trauma caused to all ED staff due to lack of timely, quality care, and experiences physical and verbal violence that can occur when patients are increasingly agitated.

Emergency physicians report difficulty in trying to navigate a complex, fractured service system to get urgently required mental health care for already vulnerable patients, especially in cases of homelessness, young people in regional towns, and for Aboriginal and Torres Strait Islander people. Nationally, Aboriginal and Torres Strait Islander people account for 13% of mental health presentations and at are 4.6% more likely to present for mental health than other Australians.[8] EDs and hospitals can be culturally unsafe for Aboriginal and Torres Strait Islander people. Considering this, community-

[4] Pascoe, S.E., Aggar, A. & Penman, O. 2022. Wait times in an Australian emergency department: A comparison of mental health and non-mental health patients in a regional emergency department. *International Journal of Mental Health Nursing.* Vol.31.

[5] Organisation for Economic Cooperation and Development (OECD). OECD Health Statistics 2015. Retrieved from https://stats.oecd.org/

[6] Allison, S., Bastiampillai, T., Licinio, J., Fuller, D. A., Bidargaddi, N., & Sharfstein, S. S. (2018). When should governments increase the supply of psychiatric beds? Molecular Psychiatry, 23(4), 796.

[7] Pascoe, S.E., Aggar, A. & Penman, O. 2022. Wait times in an Australian emergency department: A comparison of mental health and non-mental health patients in a regional emergency department. *International Journal of Mental Health Nursing.* Vol.31.

[8] Australian Institute of Health and Welfare, 2022. Mental health services in Australia. Canberra: Australian Institute of Health and Welfare. *Available from:* https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments#data-source

based services tailored to the needs of Aboriginal and Torres Strait Islander people must be prioritised, particularly to help reduce need for tertiary based mental health care.

6) Recommendation: Prioritise planning, and development of in-patient and community-based mental health beds based on population access needs, and to reduce access block in EDs.

7. Prevention and early intervention

ACEM believes that investment in improved access to care in the community for patients with mental health and other chronic conditions, alongside family violence, substance abuse and psychosocial problems, will improve health and wellbeing and decrease the need for episodic acute care in an ED. The NSW Government needs to continuously give effect to the social determinants of health in its policy decisions and particularly the provision of safe, affordable housing so that no one is ever discharged from hospital to homelessness. Addressing these health determinants will decrease demand on acute care and allow people to engage meaningfully in community-based services to help keep them well.

There is a group of people in society that struggles to engage with community-based models of care and instead are managed by a combination of police, ambulance and EDs. This is not conducive to recovery or maintaining a reasonable level of mental health.

Many people cycle for months or years through homelessness, rehabilitation, mental health wards and the courts. This model of refuge and short-term support does not focus on longer-term welfare and recovery. For these patients, particularly those with psychosocial and behavioural problems, usual care in the ED offers containment, crisis review and attention to immediate needs. However, the severely limited availability in the public health system of long-term psychological services for complex psychological trauma highlights the real lack of options for recovery for the people in greatest need. The loss of the community mental health model, which offered psychosocial support as well as recovery services, and the transfer of a limited number of eligible patients to the National Disability Insurance Scheme has compounded inequities and fragmentation in NSW mental health system.

8. Conclusion

ACEM is committed to working in partnership with the New South Wales Government, mental health stakeholders and consumers to improve current service delivery and the multitude of system failures and lack of access to services across the spectrum of need that currently exist.

Thank you again for the opportunity to provide feedback to this consultation. If you require further information, please do not hesitate to contact the ACEM Policy and Advocacy Manager

Yours sincerely

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